APPLICATION FOR REPEAT EXAMINATION FOR HEALTH FACILITY ADMINISTRATORS

State Form 52564 (2-06)
Approved by State Board of Accounts, 2006

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2051
E-mail: pla6@pla.IN.gov

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

APPLICATION FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
LICENSE NUMBER	

APPLICANT
Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

DO NOT WRITE ABOVE THIS LINE

Check the portion to be repeated: ☐ NAB Examination ☐ Indiana Jurisprudence Examination

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number *
Address (*number and street or rural route*)		
City	State	ZIP code
Telephone number (*daytime*) ( )	Email address	
Name of school	Date of graduation (*month, day, year*)	

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including the location, date and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied licensure, registration, certification, or permit to practice as a health facility administrator or any regulated health occupation in any state (including Indiana) or country? ☐ Yes ☐ No
3. Are you now being or have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No
4. Have you ever been convicted of, pled guilty or nolo contendre to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol or other drugs? ☐ Yes ☐ No
   B. To any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*) ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

If you answered "Yes" on your original application and submitted documentation, please check here: ☐

You only need to submit additional information if circumstances have changed since you last submitted an explanation regarding these questions.

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Signature of applicant	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization, or institution to release to the Professional Licensing Agency and the Indiana State Board of Health Facility Administrators any files, documents, records, or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives, in connection with the processing of my application for a health facility administrators license.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency and the Indiana State Board of Health Facility Administrators to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations and institutions, any information which is material to my application, and I hereby specifically release the Agency, and the Board, from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear and affirm that I have read the above statements and agree to the same.

Signature of applicant	Date signed (*month, day, year*)